DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

CHAPTER 89

MENTAL HEALTH SERVICES

Subchapter 1

Mental Health Services Plan

DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

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Subchapter 1

Mental Health Services Plan

Rules 01 and 02 reserved

37.89.103 MENTAL HEALTH SERVICES PLAN, DEFINITIONS As used in this subchapter, unless expressly provided otherwise, the following definitions apply:

(1) "Adult" means an individual that is not a youth as defined in this rule.

(2) "Applicant" means an individual for whom the process to determine member eligibility has been initiated but not completed.

(3) "Correctional or detention facility" means:

(a) the Montana state prison, including the Warm Springs correctional facilities;

(b) the Montana women's correctional center;

(c) the Pine Hills youth correctional facility;

(d) the Riverside youth correctional facility;

(e) a department of corrections boot camp;

(f) a juvenile detention center;

(g) a city or county criminal detention facility; or

(h) any privately operated or out-of-state facility that the state of Montana may choose to utilize in place of one of the above facilities or categories of facilities.

(4) "Covered diagnosis" means a diagnosis for which the mental health services plan provides covered services to members, as specified in ARM 37.89.114.

(a) A "covered diagnosis" means one of the ICD-9-CM diagnosis codes numbered 290, 293, 293.0 through 302, 302.2, 302.4, 302.6, 302.84 through 302.89, 306, 306.0 through 307, 307.1 through 307.3, 307.46, 307.5 through 307.80, 307.82 through 312.30, 312.32 through 314.9 and 316.

(5) "Emergency" means a serious medical or behavioral condition resulting from mental illness which arises unexpectedly and manifests symptoms of sufficient severity to require immediate care to avoid jeopardy to the life or health of the member or harm to another person by the member.

(6) "Family" means a group of two or more persons related by birth, marriage or adoption who live together. Family members are considered to live together even though a family member may reside temporarily in a residential treatment setting.

(7) "Federal poverty level" or "FPL" means the 2000 poverty guidelines for the 48 contiguous states and the District of Columbia as published under the "Annual Update of the HHS Poverty Guidelines" in the Federal Register on February 15, 2000 and subsequent annual updates.

(8) "Medically necessary" is defined as provided in ARM 37.82.102.

(9) "Member" means, with respect to the plan, an individual (or, as the context allows, the parent or guardian of the individual) eligible, according to the requirements of ARM 37.89.106, for services and receiving or attempting to receive services under the plan.

(10) "Mental health services plan" or "plan" means the mental health services program established in this subchapter.

(11) "Mental health services" means services covered as specified in ARM 37.89.114 when provided with respect to a covered diagnosis.

(12) "Provider" means a person or entity that has enrolled and entered into a provider agreement with the department in accordance with the requirements of ARM 37.89.115 to provide mental health services to members.

(13) "Provider agreement" means the written enrollment agreement entered into between the department and a person or entity to provide mental health services to recipients.

(14) "Serious emotional disturbance (SED)" means with respect to a youth between the ages of six and 17 years that the youth meets the following requirements of (14)(a) and either (14)(b) or (14)(c):

(a) The youth has been determined by a licensed mental health professional as having a mental disorder with a primary diagnosis falling within one of the following DSM-IV (or successor) classifications when applied to the youth's current presentation (current means within the past 12 calendar months unless otherwise specified in the DSM-IV) and the diagnosis has a severity specifier of moderate or severe:

(i) childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90);

(ii) oppositional defiant disorder (313.81);

(iii) autistic disorder (299.00);

(iv) pervasive developmental disorder not otherwise specified (299.80);

(v) asperger's disorder (299.80);

(vi) separation anxiety disorder (309.21);

(vii) reactive attachment disorder of infancy or early childhood (313.89);

(viii) schizo affective disorder (295.70);

(ix) mood disorders (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);

(x) obsessive-compulsive disorder (300.3);
(xi) dysthymic disorder (300.4);
(xii) cyclothymic disorder (301.13);
(xiii) generalized anxiety disorder (overanxious disorder) (300.02);
(xiv) posttraumatic stress disorder (chronic) (309.81);
(xv) dissociative identity disorder (300.14);
(xvi) sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89);
(xvii) anorexia nervosa (severe) (307.1);
(xviii) bulimia nervosa (severe) (307.51);
(xix) intermittent explosive disorder (312.34); and
(xx) attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above.

(b) As a result of the youth's diagnosis determined in (14)(a) and for a period of at least six months, or for a predictable period over six months, the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres, to a significant degree, well outside normative developmental expectations, that cannot be attributed to intellectual, sensory, or health factors:

(i) has failed to establish or maintain developmentally and culturally appropriate relationships with adult care givers or authority figures;

(ii) has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships;

(iii) has failed to demonstrate a developmentally appropriate range and expression of emotion or mood;

(iv) has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation settings;

(v) has displayed behavior that is seriously detrimental to the youth's growth, development, safety or welfare, or to the safety or welfare of others; or

(vi) has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

(c) In addition to mental health services, the youth demonstrates a need for specialized services from at least one of the following human service systems during the previous six months:

(i) education services, due to the diagnosis determined in (a), as evidenced by identification as a child with a disability as defined in 20-7-401(4), MCA with respect to which the youth is currently receiving special education services;

(ii) child protective services as evidenced by temporary investigative authority, or temporary or permanent legal custody;

(iii) the juvenile correctional system, due to the diagnosis determined in (14)(a), as evidenced by a youth court consent adjustment or consent decree or youth court adjudication; or

(iv) current alcohol/drug abuse or addiction services as evidenced by participation in treatment though a state-approved program or with a certified chemical dependency counselor.

(d) Serious emotional disturbance (SED) with respect to a youth under six years of age means the youth exhibits a severe behavioral abnormality that cannot be attributed to intellectual, sensory, or health factors and that results in substantial impairment in functioning for a period of at least six months or is predicted to continue for a period of at least six months, as manifested by one or more of the following:

(i) atypical, disruptive or dangerous behavior which is aggressive or self-injurious;

(ii) atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;

(iii) atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual;

(iv) lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;

(v) indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child; or

(vi) inappropriate and extreme fearfulness or other distress which does not respond to comfort by care givers.

(15) "Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (15)(a), (b) or (c). The person must also meet the requirements of (15)(d). The person:

(a) has been involuntarily hospitalized at least 30 consecutive days because of a mental disorder at Montana state hospital (Warm Springs campus) at least once;

(b) has a DSM-IV diagnosis with a severity specifier of moderate or severe of:

(i) schizophrenic disorder (295);

(ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82);

(iii) mood disorder (293.83, 296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89);

(iv) amnestic disorder (294.0, 294.8);

(v) disorder due to a general medical condition (310.1);

(vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;

(vii) anxiety disorder (300.01, 300.21, 300.3); or

(c) has a DSM-IV diagnosis with a severity specifier of moderate or severe of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least six months or for an obviously predictable period over six months; and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at least two of the following:

(i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;

(ii) the person is unable to work in a full-time competitive situation because of mental illness;

(iii) the person has been determined to be disabled due to mental illness by the social security administration;

(iv) the person maintains a living arrangement only with ongoing supervision, is homeless or is at imminent risk of homelessness due to mental illness; or

(v) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes increased symptoms of psychosis, self-injury, suicidal or homocidal intent or psychiatric hospitalization.

(16) "Total family income" means the total annual gross cash receipts, as defined by the bureau of the census and cited in the "Annual Update of the HHS Poverty Guidelines" promulgated each year by the United States Office of Management and Budget, of all members of a family. Regular and continuing sources of income will be appropriately annualized for purposes of determining the annual income level. Extraordinary and nonrecurring income will be considered only for the 12 month period following receipt.

(a) Total family income does not include:

(i) money received as assets drawn down such as withdrawals from a bank or the sale of a house or a car; or

(ii) income tax refunds, gifts, loans, one-time insurance payments, except as beneficiary of a life insurance policy, or compensation for injury.

(17) "Youth" means an individual who has not yet attained 18 years of age, except that for purposes of the definition of serious emotional disturbance, "youth" may include an individual who has not yet attained 21 years of age if the person is enrolled in a full-time special education program.

(18) The department hereby adopts and incorporates by reference the ICD-9-CM diagnosis codes with meanings found in the St. Anthony's ICD-9-CM Code Book (1998) effective October 1, 1998 through September 30, 1999, published by St. Anthony Publishing. The department also hereby adopts and incorporates by reference the DSM-IV diagnosis codes with meanings found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994), published by the American Psychiatric Association of Washington, DC. These systems of coding provide the codes and meanings of the diagnostic terms commonly used by treating professionals and are incorporated herein in order to provide common references for purposes of the provision of services through the mental health services plan. Copies of applicable portions of the ICD-9-CM and the DSM-IV may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller, P.O. Box 202905, Helena, MT 59620-2905. (History: Sec. 41-3-1103, 52-1-103, 53-2-201, 53-6-113, 53-6-131, 53-6-701 and 53-21-703, MCA; IMP, Sec. 41-3-1103, 52-1-103, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-21-139, 53-21-202 and 53-21-701, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3307, Eff. 12/18/98; AMD, 1999 MAR p. 308, Eff. 2/12/99; AMD, 1999 MAR p. 1806, Eff. 7/1/99; TRANS & AMD, from SRS, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 989, Eff. 6/8/01; EMERG, AMD, 2002 MAR p. 3417, Eff. 12/1/02; AMD, 2003 MAR p. 653, Eff. 3/28/03; AMD, 2004 MAR p. 84, Eff. 1/1/04.)

Rules 04 and 05 reserved

37.89.106 MENTAL HEALTH SERVICES PLAN, MEMBER ELIGIBILITY

(1) An individual is eligible for covered services under the plan if:

(a) the individual is a youth with a serious emotional disturbance or an adult with a severe disabling mental illness; and the family of which the individual is a member has a total family income, without regard to other family resources, at or below 150% of the most recently published federal poverty level (FPL);

(b) the individual has been denied medicaid eligibility, is ineligible for medicaid by virtue of being a patient in an institution for mental diseases, or has applied for medicaid and the application is pending. An individual who meets medicaid eligibility requirements but does not apply for medicaid is not eligible to receive services under the plan;

(c) the individual is under the age of 19 years and the individual has been denied enrollment in Montana children's health insurance program (CHIP), as established in ARM Title 37, chapter 79;

(d) the individual is an adolescent who has met the eligibility requirements of the plan as a youth with serious emotional disturbance, but who will not meet the eligibility requirements of the plan as an adult with severe and disabling mental illness. The individual may continue to be eligible as an adolescent for the purpose of transition to independent living until the age of 21, provided the individual continues to meet income requirements; and

(e) the total number of children and the total number of adults who can be eligible for MHSP at any time is within the limits set by the department as provided in (6) of this rule.

(2) If a person who is determined eligible for the plan based upon a pending medicaid application is later determined to be eligible for medicaid:

(a) any payment received by the provider under the plan for services provided during the effective period of medicaid eligibility must be refunded to the department; and

(b) all services provided to the individual during the effective period of medicaid eligibility may be billed to medicaid according to applicable medicaid requirements.

(3) For purposes of determining the total family income under (1):

(a) the family may not spend down to the required level of income;

(b) family debts, expenses and other financial circumstances are not considered; and

(c) the most recently published FPL is the FPL most recently published in the Federal Register as of the end of the month immediately preceding the month in which the application is submitted.

(4) Members must comply with the procedures specified by the department in accordance with ARM 37.89.118 to obtain or access services under the plan.

(5) This subchapter is not intended to and does not establish an entitlement for any individual to be determined eligible for or to receive any services under the plan. The department may, in its discretion, limit services, rates, eligibility and the number of persons determined eligible under the plan based upon such factors as availability of funding, the degree of financial need, the degree of medical need or other factors.

(a) If the department determines with respect to the plan that it is necessary to reduce, limit, suspend or terminate eligibility or benefits, reduce provider reimbursement rates, reduce or eliminate service coverage or otherwise limit services, benefits or provider participation rates, in a manner other than provided in this subchapter, the department may implement such changes by providing 10 days advance notice published in Montana major daily newspapers with statewide circulation, and by providing:

(i) 10 days advance written notice of any individual eligibility and coverage changes to affected members; and

(ii) 10 days advance written notice of coverage, rate and provider participation changes to affected providers.

(6) If the department determines that the average per-case cost of mental health services plan expenditures times the number of enrollees will exceed total appropriations, it will suspend enrollment of new recipients.

(a) the department will place the names of persons applying for enrollment who would be eligible but for the suspension of new enrollments on a waiting list.

(b) when total MHSP enrollment falls below the number which, when multiplied by the average per-case cost, equals total appropriations, the department will enroll persons whose names appear on the waiting list. Enrollment from the waiting list will be made in order of severity of need, with qualified applicants whose needs are most severe first as determined by the department based on the following:

(i) diagnosis;

(ii) functional impairment as evaluated by a licensed mental health professional designated by the department; or

(iii) availability of appropriate alternative means to obtain treatment.

(c) no person enrolled in the MHSP on September 4, 2000, shall be determined ineligible solely as a result of the determination by the department provided for in (6)(a).

(d) notwithstanding the provisions of (6)(a) through (c) of this rule, the department may enroll a qualified applicant if the applicant is:

(i) a patient at Montana state hospital (MSH) ready for discharge; or

(ii) in imminent physical danger due to a life-threatening mental health emergency. (History: Sec. 41-3-1103, 52-2-603, 53-2-201, 53-6-113, 53-6-131, 53-6-701, 53-6-706 and 53-21-703, MCA; IMP, Sec. 41-3-1103, 52-2-603, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-6-706, 53-21-139, 53-21-202 and 53-21-702, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3307, Eff. 12/18/98; AMD, 1999 MAR p. 355, Eff. 3/1/99; AMD, 1999 MAR p. 1301, Eff. 7/1/99; EMERG, AMD, 2000 MAR p. 3177, Eff. 11/10/00; AMD, 2000 MAR p. 3418, Eff. 12/8/00; TRANS & AMD, from SRS, 2001 MAR p. 417, Eff. 1/12/01; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2002 MAR p. 3423, Eff. 12/13/02.)

Rules 07 through 13 reserved

37.89.114 MENTAL HEALTH SERVICES PLAN, COVERED SERVICES

(1) Authorized medically necessary mental health services for a covered diagnosis are covered under the plan for members, except as provided in this subchapter.

(2) Covered services for youth include:

(a) evaluation and assessment of psychiatric conditions by licensed and enrolled mental health providers;

(b) primary care providers, as defined in ARM 37.86.5001(25), for screening and identifying psychiatric conditions and for medication management;

(c) a psychotropic drug formulary, as specified in (7);

(d) medication management, including lab services necessary for management of prescribed medications medically necessary with respect to a covered diagnosis;

(e) psychological assessments, treatment planning, individual, group and family therapy, and consultations performed by licensed psychologists, licensed clinical social workers, and licensed professional counselors for treatment of covered diagnoses in private practice or in mental health centers; and

(f) mental health center services.

(3) Covered services for adults include:

(a) services provided by a licensed mental health center contracted with the department for services to adults enrolled in the plan;

(b) primary care providers, as defined in ARM 37.86.5001(25), for screening and identifying psychiatric conditions and for medication management;

(c) a psychotropic drug formulary, as specified in (7);

(d) medication management, including lab services necessary for management of prescribed medications medically necessary with respect to a covered diagnosis.

(4) This subchapter is not intended to and does not establish an entitlement for any individual to be determined eligible for or to receive any services under the plan. The category of services, the particular provider of services, the duration of services and other specifications regarding the services to be covered for a particular member may be determined and may be restricted by the department or its designee based upon and consistent with the services medically necessary for the member, the availability of appropriate alternative services, the relative cost of services, the member's treatment plan objectives, the availability of funding, the degree of financial need, the degree of medical need and other relevant factors.

(a) If the department determines with respect to the plan that it is necessary to reduce, limit, suspend or terminate eligibility or benefits, reduce provider reimbursement rates, reduce or eliminate service coverage or otherwise limit services, benefits or provider participation, in a manner other than provided in this subchapter, the department may implement such changes by providing 10 days advance notice published in Montana major daily newspapers with statewide circulation, and by providing:

(i) 10 days advance written notice of any individual eligibility and coverage changes to affected members; and

(ii) 10 days advance written notice of coverage, rate and provider participation changes to affected providers.

(5) The department may require prior authorizations for any particular services designated by the department in accordance with ARM 37.89.118.

(a) Members must comply with the procedures required by the department in accordance with ARM 37.89.118 to obtain or access services under the plan.

(6) Coverage of medically necessary mental health services for a covered diagnosis will not be denied solely because the member also has a non-covered diagnosis.

(7) The plan covers the medically necessary psychotropic medications listed in the department's mental health services plan drug formulary if medically necessary with respect to a covered diagnosis. The department may revise the formulary from time to time. A copy of the current formulary may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller, P.O. Box 202905, Helena, MT 59620-2905.

(8) Except as provided in (8)(a), the plan covers medically necessary mental health services for covered diagnoses for members who are residents of nursing facilities, regardless of whether the services are provided in the nursing facility.

(a) The plan does not cover services defined as "nursing facility services" in ARM 37.40.302 or otherwise required by law to be provided by the nursing facility and does not cover or reimburse the nursing facility for services provided by the nursing facility.

(9) The plan covers medically necessary mental health services for any covered diagnosis for a member with a primary diagnosis of mental retardation or developmental disability, but does not cover treatment, habilitation or other services required by the member's mental retardation or developmental disability.

(10) The plan does not cover:

(a) any form of transportation services;

(b) detoxification, drug or alcohol evaluation, treatment or rehabilitation, regardless of the member's diagnosis; and

(c) services provided to a nonmember who is eligible on an emergency basis during a hospital emergency room visit.

(11) A member who is an inmate in or incarcerated in a correctional or detention facility is not entitled to services under the plan, except as specifically provided in these rules.

(a) The plan covers discharge planning services in relation to a covered diagnosis prior to release from a correctional or detention facility for a member who is:

(i) within 60 days of release;

(ii) a youth under the custody of the department's division of child and family services or the department of corrections and who is in a correctional or detention facility;

(iii) a prisoner in a correctional or detention facility;

(iv) a forensic patient, as specified in (8)(a), admitted to the Montana state hospital; or

(v) being held in a juvenile correction facility.

(b) A member incarcerated in a local government criminal detention facility who has not been adjudicated may receive medically necessary mental health services for covered diagnosis during incarceration, except that the plan does not cover the member's security or detention needs.

(c) A member may receive medically necessary mental health services for covered diagnoses after leaving the correctional or detention facility, except that the plan does not cover the individual's security or detention needs.

(12) This subchapter is not intended to and does not establish an entitlement for any individual to be determined eligible for or to receive services under the plan. The department may limit services, rates, eligibility or the number of persons determined eligible under the plan based upon such factors as availability of funding, the degree of financial need, the degree of medical need or other factors.

(a) If the department determines with respect to the plan that it is necessary to reduce, limit, suspend or terminate eligibility or benefits, reduce provider reimbursement rates, reduce or eliminate service coverage or otherwise limit services, benefits or provider participation, in a manner other than provided in this subchapter, the department may implement such changes by providing 10 days advance notice published in Montana major daily newspapers with statewide circulation, and by providing:

(i) 10 days advance written notice of any individual eligibility and coverage changes to affected members; and

(ii) 10 days advance written notice of coverage, rate and provider participation changes to affected providers. (History: Sec. 41-3-1103, 52-1-103, 52-2-603, 53-2-201, 53-6-113, 53-6-131, 53-6-706 and 53-21-703, MCA; IMP, Sec. 41-3-1103, 52-1-103, 52-2-603, 53-1-405, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-701, 53-6-705, 53-6-706, 53-21-139, 53-21-202, 53-21-701 and 53-21-702, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3307, Eff. 12/18/98; AMD, 1999 MAR p. 308, Eff. 2/12/99; AMD, 1999 MAR p. 1806, Eff. 7/1/99; TRANS & AMD, from SRS, 2001 MAR p. 27, Eff. 1/12/01; EMERG, AMD, 2001 MAR p. 1747, Eff. 9/7/01; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, EMERG, AMD, 2002 MAR p. 3423, Eff. 12/13/02; AMD, 2003 MAR p. 653, Eff. 3/28/03.)

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37.89.115 MENTAL HEALTH SERVICES PLAN, PROVIDER PARTICIPATION (1) Providers of services may request enrollment in the plan and may participate in the plan only upon approval of enrollment and according to the written provider agreement between the provider and the department and the requirements of this subchapter.

(a) The provisions of ARM 37.85.402 shall apply for purposes of provider enrollment in the plan. Providers must enroll with the department's medicaid fiscal agent in the same manner and according to the same requirements applicable under the Montana medicaid program. The department may accept current medicaid enrollment for purposes of enrollment under the plan, if the provider agrees, in a form acceptable to the department, to be bound by applicable plan requirements.

(b) For purposes of enrollment in the plan, providers must be and remain enrolled in the Montana medicaid program for the same category of service and must meet the same qualifications and requirements that apply to the provider's category of service under the Montana medicaid program.

(2) Providers in the following categories may request enrollment in the plan:

(a) mental health centers;

(b) psychiatrists;

(c) primary care providers, as defined in ARM 37.86.5001(25);

(d) licensed psychologists;

(e) licensed clinical social workers;

(f) licensed professional counselors; and

(g) outpatient pharmacies.

(3) The department may, in its discretion, enroll as providers individuals or entities in the categories of providers specified in (2) if they apply for enrollment, if they are appropriately licensed, certified, or otherwise meet the minimum qualifications required by the department for the category of service, and if they agree to the terms of the provider agreement.

(a) Nothing in these rules requires the department to enroll any particular provider or category of provider to provide services under the plan. The department, in its discretion, may deny enrollment to any provider or category of provider. The department may, in its discretion, limit services, rates, eligibility or the number of persons determined eligible under the plan based upon such factors as availability of funding, the degree of financial need, the degree of medical need or other factors.

(i) If the department determines with respect to the plan that it is necessary to reduce, limit, suspend or terminate eligibility or benefits, reduce provider reimbursement rates, reduce or eliminate service coverage or otherwise limit services, benefits or provider participation, in a manner other than provided in this subchapter, the department may implement such changes by providing 10 days advance notice published in Montana major daily newspapers with statewide circulation, and by providing:

(A) 10 days advance written notice of any individual eligibility and coverage changes to affected members; and

(B) 10 days advance written notice of coverage, rate and provider participation changes to affected providers.

(b) A provider who is denied enrollment has no right to an administrative review or fair hearing as provided in ARM 37.5.304, et seq. or any other department rule.

(c) Enrollment does not imply or create any guarantee of or right to any level of utilization or reimbursement for any provider.

(4) The provisions of ARM Title 37, chapter 85, subchapter 4 and other medicaid program laws, rules and regulations regarding particular categories of service apply to participating providers and the services provided under the plan, except as specifically provided in this subchapter or the provider agreement.

(a) The provisions of ARM 37.85.414 regarding maintenance of records and related issues applies to providers of mental health services under the plan.

(i) The department and any legally authorized agency of the state or federal government may inspect any facilities and records pertaining to services provided under the plan, including those of any provider participating in the plan.

(ii) Upon request, providers must provide complete copies of medical records to the department or its agents.

(b) For all members, providers must comply with the same confidentiality requirements that apply to information regarding medicaid recipients.

(c) The department may collect from a provider any overpayment under the plan as provided with respect to medicaid overpayments in ARM 37.85.406(9) through (10)(b). The department may recover overpayments by withholding or offset as provided in ARM 37.85.513(1).

(i) The notice and hearing provisions of ARM 37.5.310 and 37.85.512 apply to a department overpayment determination under (4)(c).

(d) The department may sanction a provider based upon the same grounds that sanctions may be imposed against a provider under the Montana medicaid program, except that a sanction may not be imposed with respect to a provider's conduct or omission under the plan based upon a medicaid requirement or prohibition that is not applicable to the plan under these rules.

(i) Sanctions imposed under (4)(d) may include termination or suspension from plan participation and required attendance at provider education sessions at the provider's expense.

(ii) The department must consider the factors listed in ARM 37.85.505 in determining whether to impose a sanction and what sanction, if any, to impose. The provisions of ARM 37.85.506 and 37.85.507 shall apply to any sanction imposed under (4)(d).

(iii) The notice and hearing provisions of ARM 37.5.310 and 37.85.512 apply to a department sanction determination under (4)(d).

(5) An enrolled provider has no right to an administrative review or fair hearing as provided in ARM 37.5.304, et seq., 37.85.411 or any other department rule for:

(a) a determination by the department or its agent that a particular service, item or treatment is not medically necessary;

(b) a denial of approval, authorization, certification or coverage of a service available from the provider or provided by the provider to a member; or

(c) any other issues related to the provider agreement, the provision of services to recipients or the plan, except as specifically permitted by this subchapter.

(6) An enrolled provider shall be provided an opportunity for administrative review and fair hearing as provided in ARM 37.5.310 to contest a denial of correct payment by the department to the provider for a service provided to a member if:

(a) the department has determined that the particular service, including the amount, duration and frequency of the service, is medically necessary for the member to treat a covered diagnosis and has authorized the particular service for the member according to applicable requirements; and

(b) the department has determined that the member is eligible for the plan according the requirements of ARM 37.89.106.

(7) For purposes of applying the provisions of any medicaid rule as required by this subchapter, references in the medicaid rule to "medicaid" or the "Montana medicaid program" or similar references, shall be deemed to apply to the plan as the context permits. (History: Sec. 2-4-201, 41-3-1103, 53-2-201, 53-6-113 and 53-21-703, MCA; IMP, Sec. 2-4-201, 41-3-1103, 53-1-601, 53-2-201, 53-6-113, 53-6-116, 53-6-701, 53-6-705, 53-21-202, 53-21-701 and 53-21-702, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1809, Eff. 7/1/99; TRANS, from SRS, 2001 MAR p. 27; EMERG, EMERG, AMD, 2002 MAR p. 3423, Eff. 12/13/02; AMD, 2003 MAR p. 653, Eff. 3/28/03.)

Rules 16 and 17 reserved

37.89.118 MENTAL HEALTH SERVICES PLAN, AUTHORIZATION REQUIREMENTS (1) The prior authorization, notification and other provisions of ARM 37.88.101 apply to the mental health services plan provided in this subchapter.

(a) For purposes of applying the provisions of ARM 37.88.101 to the mental health services plan, references in ARM 37.88.101 to "medicaid recipient" and "recipients" shall be deemed references to mental health services plan members, and references to the "Montana medicaid program" shall be deemed references to the mental health services plan.

(b) Services provided to adult members of the mental health services plan are exempt from the prior authorization provisions of ARM 37.88.101. (History: Sec. 53-2-201 and 53-21-703, MCA; IMP, Sec. 53-2-201, 53-21-202 and 53-21-701, MCA; NEW, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2001 MAR p. 27; EMERG, AMD, 2002 MAR p. 3417, Eff. 12/1/02; AMD, 2003 MAR p. 653, Eff. 3/28/03.)

37.89.119 MENTAL HEALTH SERVICES PLAN, PREMIUM PAYMENTS, AND MEMBER COPAYMENTS (1) A member of the plan must pay to the provider the following copayment not to exceed the cost of the service:

(a) for each outpatient visit or service, other than pharmacy services, $10 or a lesser amount designated by the department;

(b) for each filling of a prescription, the lesser of the cost of that particular filling or $25, or a lesser amount designated by the department; and

(c) for each out-of-home admission, $50 or a lesser amount designated by the department.

(2) The medicaid copayment provisions of ARM 37.85.204 are not applicable to mental health services provided under the plan. (History: Sec. 53-2-201, 53-6-113 and 53-6-131, MCA; IMP, Sec. 53-1-405, 53-1-601, 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-131, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3307, Eff. 12/18/98; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2001 MAR p. 27.)

Rules 20 through 24 reserved

37.89.125 MENTAL HEALTH SERVICES PLAN, PROVIDER REIMBURSEMENT (1) Reimbursement of enrolled providers for mental health services covered under the plan and provided to plan members is as provided in ARM Title 37, chapters 5, 40, 82, 85, 86 and 88 for the same service or category of service under the Montana medicaid program, except as otherwise provided in this subchapter.

(a) For services covered under the plan, reimbursement under the plan is subject to the same requirements, restrictions, limitations, rates, fees and other provisions that would apply to the service if it were provided to a medicaid recipient, except as otherwise provided in these rules. However, if a service is not covered under the plan, the fact that the service is or would be covered by medicaid if provided to a medicaid recipient, does not entitle the provider, member or any other person or entity to coverage or reimbursement of the service under the plan.

(i) For purposes of applying medicaid rules to plan services, a person eligible for the plan under ARM 37.89.106 need not be medicaid eligible.

(2) Provider claims for mental health services provided to members under the plan must be submitted to the department's medicaid management information system (MMIS) contractor according to requirements set forth in ARM 37.85.406. Payments will be made to the provider through the department's medicaid MMIS contractor.

(3) Providers must accept the amounts payable under this rule as payment in full for services provided to members. For purposes of this rule, the requirements of ARM 37.85.406 regarding payment in full apply to the provider, except as provided in this subchapter.

(a) Providers may bill a member who fails to show up for a scheduled service if such billing is consistent with a written policy maintained and posted by the provider, if the member has been informed of the policy in writing and if the policy applies equally to private pay patients and members.

(4) The provisions of ARM 37.85.407 apply with respect to third party resources and seeking payment from these sources. (History: Sec. 53-2-201, 53-6-113 and 53-21-703, MCA; IMP, Sec. 53-1-601, 53-2-201, 53-6-101, 53-6-116, 53-6-701, 53-6-705, 53-21-202 and 53-21-702, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 355, Eff. 3/1/99; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS & AMD, from SRS, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2002 MAR p. 3423, Eff. 12/13/02.)

Rules 26 through 30 reserved

37.89.131 MENTAL HEALTH SERVICES PLAN, MEMBER NOTICE, GRIEVANCE AND RECONSIDERATION AND RIGHTS (1) The department or its designee must notify the member or the member's designated representative in writing of a decision denying eligibility or a request for services. The requirements of ARM 37.5.505 do not apply to the notice. The notice will state:

(a) the member's name and identifying information;

(b) a statement of the decision, including the specific services, dates and other information necessary to identify the matter at issue;

(c) a concise statement of the reasons for the decision; and

(d) an explanation of how to request a grievance or reconsideration regarding the determination.

(2) If the department fails to provide notice or fails to timely provide notice or if a notice required by (1) fails to comply substantially with the requirements of (1), the remedy is the provision of a new notice which does comply substantially with (1) and a new opportunity to request a reconsideration regarding the decision specified in the notice. A failure to give adequate or timely notice under (1) does not entitle the member to an authorization for the services that were denied.

(3) A member has the right to any applicable grievance processes provided by the department's review designee referred to in ARM 37.89.118 and, following exhaustion of such grievance processes, an informal reconsideration as provided in ARM 37.5.318(5)(a) regarding a denial or termination of plan eligibility, a denial of authorization or coverage of services, a determination that a member is liable to the department as provided in ARM 37.89.106 based upon a misrepresentation or failure to provide notification of changes in income or family composition, or a determination that a member is liable to the provider as provided in ARM 37.89.106 based upon failure to apply for plan eligibility within 60 days following completion of emergency treatment.

(4) The department or its designee may request additional supporting information or documentation from the member or the provider for purposes of a grievance or informal reconsideration.

(a) The department will consider the written materials submitted and the rationale for the decision. In its discretion, if the department finds that resolution of the issues would be aided, the department may contact persons involved in the case, interested agencies or mental health professionals and may request that the member, the member's representative, a mental health professional, a provider representative or other appropriate persons to appear in person or by telephone conference to discuss the case.

(b) The department must make a decision on the informal reconsideration and notify the member or the member's representative in writing of the decision.

(5) A member must request a grievance according to the requirements specified by the department's designee.

(6) A member must request an informal reconsideration within 30 days after receiving notice of the grievance decision. A member that does not timely request an informal reconsideration is deemed to have accepted the determination and is not entitled to any further notice or review opportunity.

(7) A member is not entitled to continuation of benefits under these rules, ARM 37.5.316 or 42 CFR, part 431, subpart E.

(8) A provider is not entitled to payment for services provided after the effective date of a denial of authorization.

(9) A member is entitled only to the processes specifically provided in this rule to contest an adverse decision by the department or its designee. A member is not entitled to any administrative review or hearing procedure under ARM 37.5.304, et seq., or other department rule, regarding a denial or termination of plan eligibility, a denial of authorization or coverage of services, or any other issue arising under the plan.

(10) A member is not entitled to any grievance, reconsideration, review, hearing or other appeal process with respect to changes in eligibility coverage or other plan benefits which result from generally applicable changes in eligibility requirements, coverage provisions, rates, imposition of limitations or other changes. (History: Sec. 2-4-201, 53-2-201, 53-6-113 and 53-6-706, MCA; IMP, Sec. 2-4-201, 53-1-601, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-706 and 53-21-202, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3307, Eff. 12/18/98; AMD, 1999 MAR p. 308, Eff. 2/12/99; AMD, 1999 MAR p. 355, Eff. 3/1/99; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2001 MAR p. 27.)

Rules 32 through 34 reserved

37.89.135 MENTAL HEALTH SERVICES PLAN, TRANSITION FROM RULES IN EFFECT PRIOR TO JULY 1, 1999 (1) Notwithstanding any provision of this subchapter, under no circumstances will the plan cover services provided prior to July 1, 1999.

(2) Services provided prior to July 1, 1999 will be subject to the applicable rules in effect prior to July 1, 1999. Member eligibility, service coverage and provider reimbursement will be governed by the rules in effect with respect to the date of service, regardless of any change in the contractual relationship between the department and the managed care organization (MCO). Services provided on or after May 1, 1999 and before July 1, 1999 which meet all requirements will be reimbursed by the MCO according to the MCO's established rates for participating and non-participating providers in effect as of April 30, 1999, unless otherwise agreed in writing by the MCO and the department. (History: Sec. 53-2-201, MCA; IMP, Sec. 53-1-601, 53-1-612, 53-2-201 and 53-21-202, MCA; NEW, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2001 MAR p. 27.)

Chapter 90 reserved